SERFF Tracking Number:	*ARBB-127790785*	*State:*	*Arkansas*
Filing Company:	*Arkansas Blue Cross and Blue Shield*	*State Tracking Number:*	*50180*
Company Tracking Number:	*34-63,34-67,34-68,34-107 R1/12, 34-130,34-135,34-137,34-138 1/12*		
TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02G.002C Any Size Group - HMO*
Product Name:	*General Amendments*		
Project Name/Number:	*Amendments/34-63,34-67,34-68, 34-107 R1/12, 34-130,34-135,34-137, 34-138 1/12*		

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield

Product Name: General Amendments	SERFF Tr Num: ARBB-127790785	State: Arkansas
TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)	SERFF Status: Closed-Approved-Closed	State Tr Num: 50180
Sub-TOI: HOrg02G.002C Any Size Group - HMO	Co Tr Num: 34-63,34-67,34-68,34-107 R1/12, 34-130,34-135,34-137,34-138 1/12	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Authors: Christi Kittler, Yvonne McNaughton, Frank Sewall, Rita Thatcher, Evelyn Laney	Disposition Date: 11/03/2011
	Date Submitted: 11/02/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Amendments	Status of Filing in Domicile: Pending
Project Number: 34-63,34-67,34-68, 34-107 R1/12, 34-130,34-135,34-137, 34-138 1/12	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Arkansas is state of domicile.
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 11/03/2011	
State Status Changed: 11/03/2011	Deemer Date:
Created By: Evelyn Laney	Submitted By: Evelyn Laney

Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms

PPACA Notes: null

SERFF Tracking Number:	*ARBB-127790785*	*State:*	*Arkansas*
Filing Company:	*Arkansas Blue Cross and Blue Shield*	*State Tracking Number:*	*50180*
Company Tracking Number:	*34-63,34-67,34-68,34-107 R1/12, 34-130,34-135,34-137,34-138 1/12*		
TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02G.002C Any Size Group - HMO*
Product Name:	*General Amendments*		
Project Name/Number:	*Amendments/34-63,34-67,34-68, 34-107 R1/12, 34-130,34-135,34-137, 34-138 1/12*		

Filing Description:

We have deleted the exclusion for Group Therapy in all of the Evidences of Coverage. The Mental Health Amendments- 34-63, 34-67, and 34-68 R1/12 have been revised to delete Group Therapy provision, as well.

We have amended the "Newborn Care in the Hospital" benefit for all groups with maternity benefits to clarify that coverage for a newborn is contingent on the Subscriber adding the newborn to the policy in accordance with Section 6.0. This is a clarification only and does not represent a benefit change.

Act 1042 of Arkansas' 88th General Assembly requires coverage for gastric pacemakers for individuals with gastroparesis. We have added a benefit for gastric pacemakers and also deleted the exclusion for gastric stimulators to comply with the new law.

We have also added a new benefit for pilot projects which may provide additional coverage depending on the pilot project we are conducting at the time.

We have added an exclusion for any provider that has been excluded from participation in any federally funded programs.

We have amended the Claim Processing and Appeals section to comply with the new federal requirements under Patient Protection and Affordable Care Act dealing with External Review as well as the Departments new External Review rule.

Autism amendment – Act 196 of Arkansas' 88th General Assembly requires coverage for autism spectrum disorder including applied behavior analysis. Therefore, we are adding a benefit for new groups and renewal groups effective October 1, 2011 to comply with the law. We are also deleting the exclusion for IDEA Covered Services in accordance with the Act.

We have amended the Preventive Health Services amendment (34-107 R1/12) to allow coverage for services provided in an Outpatient Hospital or Ambulatory Surgery Center when such services cannot be performed in the office of a Primary Care Physician."

Also attached is a Flesch Reading Ease score certification signed by an officer of the company as required by Arkansas Code Annotated §23-80-206(d).

I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19. I further certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule & Regulation 49 and the consumer information notice required by Arkansas Code Annotated §23-79-138 are incorporated in the Evidences of Coverage to which these amendments are attached.

Please feel free to contact me at 378-2165 with any questions you may have.

Company and Contact

Filing Contact Information

Evelyn Laney, Senior Compliance Analyst exlaney@arkbluecross.com
320 West Capitol, Ste 211 501-378-2165 [Phone]

SERFF Tracking Number:	*ARBB-127790785*	*State:*	*Arkansas*
Filing Company:	*Arkansas Blue Cross and Blue Shield*	*State Tracking Number:*	*50180*
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Little Rock, AR 72201 501-378-2975 [FAX]

Filing Company Information

Arkansas Blue Cross and Blue Shield	CoCode: 83470	State of Domicile: Arkansas
601 S. Gaines Street	Group Code:	Company Type:
Little Rock, AR 72201	Group Name:	State ID Number: N/A
(501) 378-2967 ext. [Phone]	FEIN Number: 71-0226428	

Filing Fees

Fee Required?	Yes
Fee Amount:	$400.00
Retaliatory?	No
Fee Explanation:	$50.00 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Arkansas Blue Cross and Blue Shield	$400.00	11/02/2011	53409547

SERFF Tracking Number:	*ARBB-127790785*	*State:*	*Arkansas*
Filing Company:	*Arkansas Blue Cross and Blue Shield*	*State Tracking Number:*	*50180*
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Product Name:	*General Amendments*		
Project Name/Number:	*Amendments/34-63,34-67,34-68, 34-107 R1/12, 34-130,34-135,34-137, 34-138 1/12*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/03/2011	11/03/2011

SERFF Tracking Number:	*ARBB-127790785*	*State:*	*Arkansas*
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Product Name:	*General Amendments*		
Project Name/Number:	*Amendments/34-63,34-67,34-68, 34-107 R1/12, 34-130,34-135,34-137, 34-138 1/12*		

Disposition

Disposition Date: 11/03/2011
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ARBB-127790785*	*State:*	*Arkansas*
Filing Company:	*Arkansas Blue Cross and Blue Shield*	*State Tracking Number:*	*50180*
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Product Name:	*General Amendments*		
Project Name/Number:	*Amendments/34-63,34-67,34-68, 34-107 R1/12, 34-130,34-135,34-137, 34-138 1/12*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes

SERFF Tracking Number:	*ARBB-127790785*	*State:*	*Arkansas*
Filing Company:	*Arkansas Blue Cross and Blue Shield*	*State Tracking Number:*	*50180*
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TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02G.002C Any Size Group - HMO*
Product Name:	*General Amendments*		
Project Name/Number:	*Amendments/34-63,34-67,34-68, 34-107 R1/12, 34-130,34-135,34-137, 34-138 1/12*		

Form Schedule

Lead Form Number: 34-63 R1/12

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/03/2011	34-63 R1/12	Certificate Amendment Amendment, Insert Page, Endorsement or Rider		Revised	Replaced Form #: 34-63 R1/12 Previous Filing #: 34-63 10/09	40.400	34-63 MHP R1-12.pdf
Approved-Closed 11/03/2011	34-67 R1/12	Certificate Amendment Amendment, Insert Page, Endorsement or Rider		Revised	Replaced Form #: 34-67 R1/12 Previous Filing #: 34-67 10/09	40.400	34-67 MHP R1-12ConvGuest.pdf
Approved-Closed 11/03/2011	34-68 R1/12	Certificate Amendment Amendment, Insert Page, Endorsement or Rider		Revised	Replaced Form #: 34-68 R1/12 Previous Filing #: 34-68 10/09	40.400	34-68 MHP R1-12.pdf
Approved-Closed 11/03/2011	34-107 R1/12	Certificate Amendment Amendment, Insert Page, Endorsement or Rider		Revised	Replaced Form #: 34-107 R1/12 Previous Filing #: 34-107 10/10	40.400	34-107 PPACA Preventive Health Services R1-12.pdf
Approved-Closed 11/03/2011	34-130 1/12	Certificate Amendment Amendment, Insert Page, Endorsement or Rider		Initial		40.400	34-130 1-12GenAmend Filing Version.pdf

SERFF Tracking Number:	*ARBB-127790785*	*State:*	*Arkansas*		
Filing Company:	*Arkansas Blue Cross and Blue Shield*	*State Tracking Number:*	*50180*		
Company Tracking Number:	*34-63,34-67,34-68,34-107 R1/12, 34-130,34-135,34-137,34-138 1/12*				
TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02G.002C Any Size Group - HMO*		
Product Name:	*General Amendments*				
Project Name/Number:	*Amendments/34-63,34-67,34-68, 34-107 R1/12, 34-130,34-135,34-137, 34-138 1/12*				
Approved-Closed 11/03/2011	34-135 1/12	Certificate Amendment Amendment, Insert Page, Endorsement or Rider	Initial	40.400	34-135 1-12 Aut GenAmendFiling Version.pdf
Approved-Closed 11/03/2011	34-137 1/12	Certificate Amendment Amendment, Insert Page, Endorsement or Rider	Initial	40.400	34-137 1-12 Aut GenAmendFiling Version.pdf
Approved-Closed 11/03/2011	34-138 1/12	Certificate Amendment Amendment, Insert Page, Endorsement or Rider	Initial	40.400	34-138 1-12GenAmend Filing Version.pdf

Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

AMENDMENT TO HEALTH ADVANTAGE EVIDENCE OF COVERAGE

The following Health Advantage Evidences of Coverage are hereby amended.

Evidence of Coverage, BlueChoice POS Plan, Form #31-02
Evidence of Coverage, BlueChoice POS Plan with Preexisting, Form #31-03
Evidence of Coverage, BlueChoice Open Access POS Plan, Form #31-04
Evidence of Coverage, BlueChoice Open Access POS Plan with Preexisting, Form #31-05
Evidence of Coverage, HSA Open Access Plan, Form #: 31-06
Evidence of Coverage, HSA Open Access Plan with Preexisting, Form #31-07

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Mental Health and Substance Abuse Services (Alcohol and Drug Abuse) is hereby amended to read as follows.

Mental Illness and Substance Abuse Services (Alcohol and Drug Abuse). Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Health Interventions to treat Mental Illness and Substance Abuse.

1. **Outpatient Health Interventions**.
   a. Coverage of Mental Illness and Substance Abuse Health Interventions during office visits and other forms of outpatient treatment, including partial or full-day program services is subject [to the Specialty Care Physician Copayment and] to the Deductible and Coinsurance set out in the Schedule of Benefits.
   b. Coverage of office visits and other outpatient treatment sessions, beyond the eighth session in a calendar year, except for medication management treatment sessions, is subject to Prior Approval from the Company. See Subsection 3, below.
2. **Inpatient, Partial Hospitalization Program and Intensive Outpatient Program Health Interventions**
   a. Coverage for Inpatient Hospitalization, Partial Hospitalization Programs or Intensive Outpatient Programs for Mental Illness or Substance Abuse Health Interventions is subject to Prior Approval from the Company. See Subsection 3 below.
      i. Inpatient Hospitalization requires a patient to receive Covered Services 24 hours a day as an inpatient in a Hospital.
      ii. Partial Hospitalization Programs generally require the patient to receive Covered Services six to eight hours a day, five to seven days per week in a Hospital.
      iii. Intensive Outpatient Programs generally require the patient to receive Covered Services lasting two to four hours a day, three to five days per week in a Hospital.
   b. Coverage is subject [to the Inpatient Hospital Copayment and] to the Deductible and Coinsurance set forth in the Schedule of Benefits.
   c. **The treating facility must be a Hospital.** See Glossary of Terms. Treatment received at a Freestanding Residential Substance Abuse Treatment Center or at a Freestanding Psychiatric Residential Treatment Facility is not a covered benefit.
3. **Prior Approval.** Coverage for many Health Interventions for the treatment of Mental Illness and Substance Abuse are subject to Prior Approval from Health Advantage. To request Prior Approval, please call the “Behavioral Health” telephone number on your ID

card. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished us at the time indicates that the proposed Health Intervention meets the Primary Coverage Criteria requirements set out in Subject 2.2 and the Applications of the Primary Care Criteria set out in Subsections 2.4.1.b, e., or f. All services, including any Health Interventions for the treatment of Mental Illness or Substance Abuse receiving Prior Approval may be limited or denied if, when the claims for the Health Intervention are received by us, investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or that any other basis for denial of the claim specified in this Evidence of Coverage exists.**

4. The following services and treatments are not covered.
   a. **Health and Behavior Assessment/Intervention.** Evaluation of psychosocial factors potentially impacting physical health problems and treatments are not covered. This includes health and behavior assessment procedures used to identify psychological, behavioral, emotional, cognitive, and social factors affecting physical health problems. See Specific Plan Exclusion, "Health Interventions."
   b. **Hypnotherapy**. Hypnotherapy is not covered for any diagnosis or medical condition. See Specific Plan Exclusion, "Health Interventions."
   c. **Marriage and Family Therapy.** Marriage and family therapy or counseling services are not covered. See Specific Plan Exclusion, "Health Interventions."
   d. **Sex Changes/Sex Therapy.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment or other treatment of sexual dysfunction including Prescription Medication and sex therapy. See Specific Plan Exclusion, "Health Interventions."

GLOSSARY OF TERMS is hereby amended to add the following new Subsections. All remaining subsections are renumbered to correlate with the change.

Mental Illness means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include only illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.)

Substance Abuse means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.

David F. Bridges, President
HMO PARTNERS, INC, d/b/a/ HEALTH ADVANTAGE
P.O. Office Box 8069, Little Rock, Arkansas 72203-8069

Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

AMENDMENT TO HEALTH ADVANTAGE EVIDENCE OF COVERAGE

The Health Advantage Evidences of Coverage are hereby amended to read as follows:

Evidence of Coverage, Conversion, Form #31-08
Evidence of Coverage, Guest Membership, Form # 31-09

Mental Illness and Substance Abuse Services (Alcohol and Drug Abuse). Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Health Interventions to treat Mental Illness and Substance Abuse.

1. **Outpatient Health Interventions**.
   a. Coverage of Mental Illness and Substance Abuse Health Interventions during office visits and other forms of outpatient treatment, including partial or full-day program services is subject [to the Specialty Care Physician Copayment and] to the Deductible and Coinsurance set out in the Schedule of Benefits.
   b. Coverage of office visits and other outpatient treatment sessions, beyond the eighth session in a calendar year, except for medication management treatment sessions, is subject to Prior Approval from the Company. See Subsection 3, below.
2. **Inpatient, Partial Hospitalization Program and Intensive Outpatient Program Health Interventions**
   a. Coverage for Inpatient Hospitalization, Partial Hospitalization Programs or Intensive Outpatient Programs for Mental Illness or Substance Abuse Health Interventions is subject to Prior Approval from the Company. See Subsection 3 below.
      i. Inpatient Hospitalization requires a patient to receive Covered Services 24 hours a day as an inpatient in a Hospital.
      ii. Partial Hospitalization Programs generally require the patient to receive Covered Services six to eight hours a day, five to seven days per week in a Hospital.
      iii. Intensive Outpatient Programs generally require the patient to receive Covered Services lasting two to four hours a day, three to five days per week in a Hospital.
   b. Coverage is subject [to the Inpatient Hospital Copayment and] to the Deductible and Coinsurance set forth in the Schedule of Benefits.
   c. **The treating facility must be a Hospital.** See Subsection Glossary of Terms. Treatment received at a Freestanding Residential Substance Abuse Treatment Center or at a Freestanding Psychiatric Residential Treatment Facility is not a covered benefit.
3. **Prior Approval.** Coverage for many Health Interventions for the treatment of Mental Illness and Substance Abuse are subject to Prior Approval from Health Advantage. To request Prior Approval, please call the "Behavioral Health" telephone number on your ID card. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished us at the time indicates that the proposed Health Intervention meets the Primary Coverage Criteria requirements set out in Subject 2.2 and the Applications of the Primary Care Criteria set out in Subsections 2.4.1.b, e., or f. All services, including any Health Interventions for the treatment of Mental Illness or Substance Abuse receiving Prior Approval may be limited or denied if, when the claims for the Health Intervention are received by us, investigation shows that a benefit exclusion or**

limitation applies, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or that any other basis for denial of the claim specified in this Evidence of Coverage exists.

4. The following services and treatments are not covered.
   a. **Health and Behavior Assessment/Intervention.** Evaluation of psychosocial factors potentially impacting physical health problems and treatments are not covered. This includes health and behavior assessment procedures used to identify psychological, behavioral, emotional, cognitive, and social factors affecting physical health problems. See Specific Plan Exclusion, "Health Interventions."
   b. **Hypnotherapy**. Hypnotherapy is not covered for any diagnosis or medical condition. See Specific Plan Exclusion, "Health Interventions."
   c. **Marriage and Family Therapy.** Marriage and family therapy or counseling services are not covered. See Specific Plan Exclusion, "Health Interventions."
   d. **Sex Changes/Sex Therapy.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment or other treatment of sexual dysfunction including Prescription Medication and sex therapy. See Specific Plan Exclusion, "Health Interventions."

GLOSSARY OF TERMS is hereby amended to add the following new Subsections. All remaining subsections are renumbered to correlate with the change.s

Mental Illness means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include only illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.)

Substance Abuse means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.

_____

David F. Bridges, President
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P.O. Office Box 8069, Little Rock, Arkansas 72203-8069

Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

AMENDMENT TO HEALTH ADVANTAGE
EVIDENCE OF COVERAGE

The Health Advantage Evidence of Coverage is hereby amended to read as follows:

Evidence of Coverage, Standard HMO, Form #31-01
Evidence of Coverage, HMO Arkansas, Form #31-10

Mental Illness and Substance Abuse Services (Alcohol and Drug Abuse). Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Health Interventions to treat Mental Illness and Substance Abuse.

1. **Outpatient Health Interventions**.
   a. Coverage of Mental Illness and Substance Abuse Health Interventions during office visits and other forms of outpatient treatment, including partial or full-day program services is subject [to the Specialty Care Physician Copayment and] to the Deductible and Coinsurance set out in the Schedule of Benefits.
   b. Coverage of office visits and other outpatient treatment sessions, beyond the eighth session in a calendar year, except for medication management treatment sessions, is subject to Prior Approval from the Company. See Subsection 3, below.
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      iii. Intensive Outpatient Programs generally require the patient to receive Covered Services lasting two to four hours a day, three to five days per week in a Hospital.
   b. Coverage is subject [to the Inpatient Hospital Copayment and] to the Deductible and Coinsurance set forth in the Schedule of Benefits.
   c. **The treating facility must be a Hospital.** See Glossary of Terms. Treatment received at a Freestanding Residential Substance Abuse Treatment Center or at a Freestanding Psychiatric Residential Treatment Facility is not a covered benefit.
3. **Prior Approval.** Coverage for many Health Interventions for the treatment of Mental Illness and Substance Abuse are subject to Prior Approval from Health Advantage. To request Prior Approval, please call the "Behavioral Health" telephone number on your ID card. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished us at the time indicates that the proposed Health Intervention meets the Primary Coverage Criteria requirements set out in Subject 2.2 and the Applications of the Primary Care Criteria set out in Subsections 2.4.1.b, e., or f. All services, including any Health Interventions for the treatment of Mental Illness or Substance Abuse receiving Prior Approval may be limited or denied if, when the claims for the Health Intervention are received by us, investigation shows that a benefit exclusion or**

limitation applies, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or that any other basis for denial of the claim specified in this Evidence of Coverage exists.

4. The following services and treatments are not covered.
   a. **Health and Behavior Assessment/Intervention.** Evaluation of psychosocial factors potentially impacting physical health problems and treatments are not covered. This includes health and behavior assessment procedures used to identify psychological, behavioral, emotional, cognitive, and social factors affecting physical health problems. See Specific Plan Exclusions, "Health Interventions."
   b. **Hypnotherapy**. Hypnotherapy is not covered for any diagnosis or medical condition. See Specific Plan Exclusions, "Health Interventions."
   c. **Marriage and Family Therapy.** Marriage and family therapy or counseling services are not covered. See Specific Plan Exclusions, "Health Interventions."
   d. **Sex Changes/Sex Therapy.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment or other treatment of sexual dysfunction including Prescription Medication and sex therapy. See Specific Plan Exclusions, "Health Interventions."

GLOSSARY OF TERMS is hereby amended to add the following new Subsections. All remaining subsections are renumbered to correlate with the change.

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Substance Abuse means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.

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David F. Bridges, President
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AMENDMENT TO HEALTH ADVANTAGE EVIDENCE OF COVERAGE

The following Health Advantage Evidences of Coverage are hereby amended.

Evidence of Coverage, Standard HMO, Form #31-01
Evidence of Coverage, BlueChoice POS Plan, Form #31-02
Evidence of Coverage, BlueChoice POS Plan with Preexisting, Form #31-03
Evidence of Coverage, BlueChoice Open Access POS Plan, Form #31-04
Evidence of Coverage, BlueChoice Open Access POS Plan with Preexisting, Form #31-05
Evidence of Coverage, HSA Open Access Plan, Form #: 31-06
Evidence of Coverage, HSA Open Access Plan with Preexisting, Form #31-07
Evidence of Coverage, Conversion Plan, Form #31-08
Evidence of Coverage, Guest Membership, Form #31-09
Evidence of Coverage, HMO Arkansas, Form #31-10

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "**Preventive Care**" is hereby amended to read as follows.

Preventive Health Services. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, Health Advantage will pay one hundred percent (100%) of the Allowable Charges for the routine preventive health services listed below when provided by a Primary Care Physician or an advanced practice nurse or physician's assistant who provides primary medical care in the areas of general practice, pediatrics, family practice, internal medicine or obstetrics/gynecology, which are performed in the Primary Care Physician's office. Coverage is also provided for certain preventive health services listed below when performed in an Outpatient Hospital or Ambulatory Surgery Center setting when the service cannot be performed in an office by a Primary Care Physician.

1. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force but not for the related treatment of disease; and
2. routine immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
3. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this subsection; and
5. the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, **Miscellaneous Health Interventions,** "Colorectal Cancer Examinations and Laboratory Tests" is hereby deleted in its entirety. All remaining subsections are hereby renumbered to correlate with the change.

GLOSSARY OF TERMS, “Primary Care Physician” is hereby amended to read as follows.

> **Primary Care Physician** means an In-Network M.D. or D.O. Physician who provides primary medical care in one of these medical specialties: General Practice, Pediatrics, Family Practice, Obstetrics/Gynecology or Internal Medicine. This also includes advanced practice nurses or physician’s assistants who provide primary medical care in these medical specialties and are performed in the Primary Care Physician’s office.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.

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David F. Bridges, President
HMO PARTNERS, INC, d/b/a/ HEALTH ADVANTAGE
P.O. Office Box 8069, Little Rock, Arkansas 72203-8069

Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

AMENDMENT TO HEALTH ADVANTAGE EVIDENCE OF COVERAGE

The following Health Advantage Evidences of Coverage are hereby amended.

Evidence of Coverage, Standard HMO, Form #31-01
Evidence of Coverage, BlueChoice POS Plan with Preexisting, Form #31-03
Evidence of Coverage, Conversion Plan, Form #31-08
Evidence of Coverage, Guest Membership, Form #31-09
Evidence of Coverage, HMO Arkansas, Form #31-10
Evidence of Coverage, HMO with Deductible, Form #31-15

The following subsection amendments are effective on January 1, 2012.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Therapy Services, "Group Therapy" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Maternity," Subsection 3. is hereby amended to read as follows.

Newborn Care in the Hospital. Provided the child's coverage becomes effective on his or her date of birth in accordance with the provisions of Section 6.0, coverage is provided for a hospital stay for the mother and newborn child of at least forty-eight (48) hours following a vaginal delivery or at least ninety-six (96) hours following a cesarean section, unless the treating provider, after consulting with the mother, discharges the mother or newborn child earlier. An Subscriber or Spouse's newborn child will be covered from the date of birth, including use of newborn nursery (for up to five (5) days or until the mother is discharged, whichever is the lesser period of time) and related services. However, if such Child is born in an Out-of-Network hospital because the Subscriber's Spouse has other health plan coverage, or if such Child is an adopted child born in an Out-of-Network hospital, nursery charges are covered up to the Allowance or Allowable Charge incurred or $2,000, whichever is less.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Miscellaneous Health Interventions" is hereby amended to add the following new Subsections.

Gastric Pacemaker Coverage. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage including the Deductible, Copayment and and/ or Coinsurance set out in the Schedule of Benefits, coverage is provided for gastric pacemakers that receive Prior Approval from Health Advantage. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the gastric pacemaker meets the Primary Coverage Criteria requirements set out in Subsection 2.2. and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. All services, including any gastric pacemaker receiving Prior Approval, must still meet all other coverage terms, conditions, and limitations, and coverage for any gastric pacemaker receiving Prior Approval may still be limited or denied if, when the claims for the gastric pacemaker are received by us, investigation shows that a benefit exclusion or limitation applies, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage.**

Pilot Project Coverage. Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, from time to time, Health Advantage may provide coverage of medical interventions that are excluded under the terms of the Plan as set out in this Evidence of Coverage, under terms, conditions, exclusions and limitations of a Company authorized Pilot Program. You can learn the medical interventions that are covered by a

Company authorized Pilot Program, and the terms, conditions, exclusions and limitations of such coverage by visiting Health Advantage's website at WWW.HEALTHADVANTAGE-HMO.COM. or by calling Customer Service.

SPECIFIC PLAN EXCLUSIONS, Health Care Providers is hereby amended to add the following new Subsection. All remaining Subsections are re-numbered to correlate with the change.

Provider, Excluded. Health Interventions received from any Provider who has been excluded from participation in any federally funded program, are not covered.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Gastric Electrical Stimulators" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Group Therapy" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

CLAIM PROCESSING AND APPEALS, Claim Processing, "Explanation of Benefit Determination" Subsection a. is hereby amended to read as follows.

The specific reason or reasons for the determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Member may learn the diagnosis and treatment codes and their descriptions);

CLAIM PROCESSING AND APPEALS, Claim Appeals to the Plan (Internal Review), "Documentation" Subsection b. is hereby amended to read as follows.

Appellant's Right to Information. Health Advantage shall provide you free of charge and sufficiently in advance of the date of the final internal adverse benefit determination to give you a reasonable opportunity to respond, reasonable access to, and copies of, all documents, records or other information that:

i. were relied upon in making the benefit determination;

ii. were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;

iii. demonstrate compliance with the terms of the Plan.; or

iv. constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

CLAIM PROCESSING AND APPEALS, Claim Appeals to the Plan (Internal Review), "Notification of Determination of Appeal to Plan" Subsection a. is hereby amended to read as follows.

The specific reason or reasons for the review determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Member may learn the diagnosis and treatment codes and their descriptions);

CLAIM PROCESSING AND APPEALS, Independent Medical Review of Claims (External Review) "Claim Appeals Subject to External Review", is hereby amended to read as follows.

1. **Claim Appeals Subject to External Review.**

   a. **Waiver of Internal Review.** If we have waived internal review, your appeal shall be to external review in accordance with this Section 7.3.

   b. **Application of Primary Coverage.** If your claim has not been the subject of a prior external review and if we have denied your claim in whole or in part because the intervention did not meet the Primary Coverage Criteria (other than under the conditions outlined in Subsections 2.4.1.a., b., c. or d.) or because of the application of a Coverage Policy, you may request an independent medical review by an Independent Review Organization in accordance with the provisions of this Subsection 7.3 provided:

i. The claim denial was upheld in whole or in part as a result of the Plan's internal review process, or

ii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination involving a pre-service claim appeal within thirty (30) days following receipt of your appeal to the Plan; or

iii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination involving a post-service claim appeal within sixty (60) days following receipt of your appeal to the Plan; or

iv. Your claim meets the requirements for expedited external review, (see Subsection 7.3.13) and you have simultaneously submitted an appeal to the Plan.

2. **Where and When to Submit External Review Appeal. .** You may request external review by sending a request marked "External Review Request" to Member Response Coordinator, Post Office Box 8069, Little Rock, Arkansas 72203. Alternatively, you may e-mail our request to APPEALS@HEALTHADVANTAGE-HMO.COM. Your request must be made within four (4) months after you were notified that the claim denial was upheld in whole or in part as a result of the Plan's internal review process. If Subsection 7.3.1.b.ii. or 7.3.1.b.iii. apply, your request may be made at the end of the thirty (30)day period or sixty (60) day period. If Subsection 7.3.1.b.iv. applies, you must file your request for external review at the same time you file your appeal to the Plan.

3 **Filing Fee.** You are required to pay a twenty-five dollar ($25) fee to submit an appeal for external review. If the external review results in a reversal of the claim denial, in whole or in part, Health Advantage will refund your filing fee. This twenty-five dollar ($25) filing fee will be waived if (1) you have previously paid seventy-five dollars ($75) in filing fees during the plan year or (2) paying of the fee will impose an undue financial hardship.

4. **Independent Review Organization and Independent Medical Reviewer**

a. **The Arkansas Insurance Commissioner** shall determine if the claim is subject to external review, and if he so determines, assign an Independent Review Organization from the list of approved Independent Review Organizations compiled and maintained by the Commissioner.

b. **The Independent Review Organization** is not affiliated with, owned by or controlled by Health Advantage. Health Advantage pays a reasonable fee to the Independent Review Organization to conduct the review, but such fee is not contingent upon the determination of the Independent Review Organization or Independent Medical Reviewer.

c. **An Independent Medical Reviewer** is a physician that is licensed in one or more States to deliver health care services and typically treats the condition or illness that is the subject of the claim under review. The Independent Medical Reviewer is not an Subscriber of Health Advantage and does not provide services exclusively for Health Advantage or for individuals holding insurance coverage with Health Advantage. The Independent Medical Reviewer has no material financial, familial or professional relationship with Health Advantage, with the Plan Administrator, with an officer or director of Health Advantage or the Plan Administrator, with the claimant or the claimant's Authorized Representative, with the health care professional that provided the intervention involved in the denied claim; with the institution at which the intervention involved in the denied claim was provided; with the manufacturer of any drug or other device used in connection with the intervention involved in the denied claim; or with any other party having a substantial interest in the denied claim.

5. **Documentation**

a. **Written Appeals.** You must submit your appeal in writing in a form and in a manner determined by the Arkansas Insurance Commissioner. You may

submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim.

b. **Authorization to Release Information.** In filing your request for external review, you must include the following authorization: "I, [Member's name], authorize HMO Partners Inc. d/b/a Health Advantage and my healthcare Provider(s) to release all medical information or records pertinent to this claim to the Independent Review Organization that is designated by Health Advantage. I further authorize such Independent Review Organization to release such medical information to any Independent Medical Reviewer(s) selected by the Independent Review Organization to conduct the review."

6. **Referral of Review Request to an Independent Review Organization.** Upon receipt of the documentation set out in Subsection 7.3.4, the Arkansas Insurance Commissioner shall immediately refer the request for external review, along with Health Advantage's initial determination of the claim and the Appeals Coordinator's internal review determination (if applicable) to an Independent Review Organization.

7. **Independent Review Organization Right to Information.** You and your treating health care professional are required to provide the Independent Review Organization and the Independent Medical Reviewer(s), upon request, access to information necessary to determine the appeal. Access to such information shall be provided not later than seven (7) business days after the date on which the request for information is received.

8. **Rejection of Request for Review by the Independent Review Organization.** The Independent Review Organization shall reject a request for review and notify you, your Authorized Representative and the Appeals Reviewer in writing within five (5) business days (or within 72 hours for an Expedited Appeal) of its determination, if it determines that the appeal does meet the standards for an appeal for external review. See Subsections 7.3.1.

9. **Rejection of the Review for Failure to Submit Requested Information.** The Independent Review Organization may reject a request for review if:

   a. you have not provided the authorization for release of medical records or information pertinent to the claim required by Subsection 7.3.4.b; or

   b. you or your health care professional have not provided information requested by the Independent Review Organization in accordance with Subsection 7.3.6.

10. **Independent Medical Review Determination.** If the Independent Review Organization does not reject the request for review in accordance with Subsections 7.3.7 or 7.3.8, it shall assign the request for review to an Independent Medical Reviewer. Such Independent Medical Reviewer shall make a determination after reviewing the documentation submitted by you, your health care professional and Health Advantage. The Independent Medical Reviewer shall consider the terms of the Evidence of Coverage to assure that the reviewer's decision is not contrary to the terms of the Plan. In making the determination the reviewer need not give deference to the determinations made by Health Advantage or the recommendations of the treating health care professional (if any).

11. **Timing of Appeal Determination.**

   a. **Standard Review.** The Independent Medical Reviewer shall complete a review on an appeal within a reasonable period of time, but in no case later than forty five (45) days after the Independent Review Organization received the appeal.

   b. **Expedited Review.** If you request an expedited review, and a health care professional certifies that the time for a standard review would seriously jeopardize your life or health or your ability to regain maximum function, the Independent Medical Reviewer shall make a determination on review in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Independent Review Organization received the request for review.

12. **Notification of Determination of Independent Medical Review.**

a. **Recipients of Notice.** Upon receipt of the determination of the Independent Medical Reviewer, the Independent Review Organization shall provide written notification of the determination to you, you health care Provider and Health Advantage.

b. **The Notification shall include**.

i. A general description of the reason for the request for external review;

ii. The date the Independent Review Organization was notified by Health Advantage to conduct the review;

iii. The date the external review was conducted;

iv. The date of the Independent Medical Reviewer's determination;

v. The principal reason(s) for the determination;

vi. The rationale for the determination; and

vii. References to the evidence or documentation, including practice guidelines, considered in the determination.

13. **Expedited External Review.**

a. **Requirement for Expedited Review.** You may submit a pre-service claim denial or a denial of a claim involving concurrent care for an expedited external review provided your health care professional certifies that the time to complete a standard review would seriously jeopardize your life or health or your ability to regain maximum function.

b. **Expedited External Review without prior Appeal to Plan (internal review).** You may request an expedited review at the same time you submit a request for an appeal to the Plan (internal review) if your health care professional certifies that the time to complete the Plan's expedited appeal process would seriously jeopardize your life or health or your ability to regain maximum function. If you make such a request, the Independent Review Organization may determine and notify you in accordance with Subsections 7.3.10.b and 7.3.11 whether you will be required to complete the internal review process.

c. **Same procedures as standard external review.** Unless otherwise specified, the provisions of this Section 7.3 applicable to independent medical review of claims apply to expedited external review of claims.

14. **Other Rights under Plan.** Your decision to submit an appeal to external review will have no effect on your other rights and benefits under the Plan.

15. **Arkansas Insurance Commissioner.** You may contact the Arkansas Insurance Commissioner for assistance. The mailing address is Arkansas Insurance Department, Attention External Review Assistance, 1200 West Third Street, Little Rock, Arkansas 72201. The telephone number is 501-371-2640 or toll free 800-282-9134. The e-mail address is insurance.consumers@arkansas.gov.

16. **Binding on the Plan.** The determination of an Independent Review Organization and an Independent Medical Reviewer is binding on both the Plan and you, except to the extent that other remedies are available under applicable federal or state law.

GLOSSARY OF TERMS, Health Interventions is hereby amended to read as follows.

Health Intervention or Intervention means an item, Medication or service delivered or undertaken primarily to diagnose, detect, treat, palliate or alleviate a medical condition or to maintain or restore functional ability of the mind or body.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.

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David F. Bridges, President
HMO PARTNERS, INC, d/b/a/ HEALTH ADVANTAGE
P.O. Office Box 8069, Little Rock, Arkansas 72203-8069

Health Advantage

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AMENDMENT TO HEALTH ADVANTAGE EVIDENCE OF COVERAGE

The following Health Advantage Evidences of Coverage are hereby amended.

RENEWAL AMENDMENT

Evidence of Coverage, Standard HMO, Form #31-01
Evidence of Coverage, BlueChoice POS Plan, Form #31-02
Evidence of Coverage, BlueChoice POS Plan with Preexisting, Form #31-03
Evidence of Coverage, BlueChoice Open Access POS Plan, Form #31-04
Evidence of Coverage, BlueChoice Open Access POS Plan with Preexisting, Form #31-05
Evidence of Coverage, HSA Open Access Plan, Form #: 31-06
Evidence of Coverage, HSA Open Access Plan with Preexisting, Form #31-07
Evidence of Coverage, HMO Arkansas, Form #31-10
Evidence of Coverage, Guest Membership, Form #31-09
Evidence of Coverage, HMO with Deductible, Form #31-15

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN is hereby amended to add the following new Subsection.

Autism Spectrum Disorder Benefits. Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage as well as the Deductible, Copayment and/or Coinsurance set out in the Schedule of Benefits, coverage is provided for Members with autism spectrum disorder that is diagnosed by a licensed doctor of medicine or licensed psychologist. Further, subject to Prior Approval from Health Advantage as well as the Deductible, Copayment and/or Coinsurance set out in the Schedule of Benefits, coverage is provided for applied behavior analysis when provided by or supervised by a Board Certified Behavioral Analyst and provided to Members under the age of 18. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage at the time indicates that the applied behavior analysis meets the Primary Coverage Criteria requirements set out in Subsection 2.2. and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. All services, including any applied behavior analysis receiving Prior Approval, must still meet all other coverage terms, conditions, and limitations, and coverage for any applied behavior analysis receiving Prior Approval may still be limited or denied if, when the claims for the applied behavior analysis are received by Health Advantage, investigation shows that a benefit exclusion or limitation applies, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage.**

SPECIFIC PLAN EXCLUSIONS, Miscellaneous Fees and Services, "IDEA Covered Services" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.

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The following Health Advantage Evidences of Coverage are hereby amended.

RENEWAL AMENDMENT

Evidence of Coverage, Standard HMO, Form #31-01
Evidence of Coverage, BlueChoice POS Plan, Form #31-02
Evidence of Coverage, BlueChoice POS Plan with Preexisting, Form #31-03
Evidence of Coverage, BlueChoice Open Access POS Plan, Form #31-04
Evidence of Coverage, BlueChoice Open Access POS Plan with Preexisting, Form #31-05
Evidence of Coverage, HSA Open Access Plan, Form #: 31-06
Evidence of Coverage, HSA Open Access Plan with Preexisting, Form #31-07
Evidence of Coverage, HMO Arkansas, Form #31-10
Evidence of Coverage, Guest Membership, Form #31-09
Evidence of Coverage, HMO with Deductible, Form #31-15

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN is hereby amended to add the following new Subsection.

Autism Spectrum Disorder Benefits. Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage as well as the Deductible, Copayment and/or Coinsurance set out in the Schedule of Benefits, coverage is provided for Members with autism spectrum disorder that is diagnosed by a licensed doctor of medicine or licensed psychologist. Further, subject to Prior Approval from Health Advantage as well as the Deductible, Copayment and/or Coinsurance set out in the Schedule of Benefits, coverage is provided for applied behavior analysis when provided by or supervised by a Board Certified Behavioral Analyst and provided to Members under the age of 18. Applied behavioral analysis services have a contract year benefit limit of fifty thousand dollars ($50,000). **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage at the time indicates that the applied behavior analysis meets the Primary Coverage Criteria requirements set out in Subsection 2.2. and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. All services, including any applied behavior analysis receiving Prior Approval, must still meet all other coverage terms, conditions, and limitations, and coverage for any applied behavior analysis receiving Prior Approval may still be limited or denied if, when the claims for the applied behavior analysis are received by Health Advantage, investigation shows that a benefit exclusion or limitation applies, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage.**

SPECIFIC PLAN EXCLUSIONS, Miscellaneous Fees and Services, "IDEA Covered Services" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.

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AMENDMENT TO HEALTH ADVANTAGE EVIDENCE OF COVERAGE

The following Health Advantage Evidences of Coverage are hereby amended.

Evidence of Coverage, BlueChoice POS Plan, Form #31-02
Evidence of Coverage, BlueChoice Open Access POS Plan, Form #31-04
Evidence of Coverage, BlueChoice Open Access POS Plan with Preexisting, Form #31-05
Evidence of Coverage, HSA Open Access Plan, Form #: 31-06
Evidence of Coverage, HSA Open Access Plan with Preexisting, Form #31-07

The following subsection amendments are effective on January 1, 2012.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, Therapy Services, "Group Therapy" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Maternity," Subsection 3. is hereby amended to read as follows.

Newborn Care in the Hospital. Provided the child's coverage becomes effective on his or her date of birth in accordance with the provisions of Section 6.0, coverage is provided for a hospital stay for the mother and newborn child of at least forty-eight (48) hours following a vaginal delivery or at least ninety-six (96) hours following a cesarean section, unless the treating provider, after consulting with the mother, discharges the mother or newborn child earlier. An Subscriber or Spouse's newborn child will be covered from the date of birth, including use of newborn nursery (for up to five (5) days or until the mother is discharged, whichever is the lesser period of time) and related services. However, if such Child is born in an Out-of-Network hospital, the Child's coverage for Out-of-Network services in the first 90 days is limited to the Allowance or Allowable Charges incurred or $2,000, whichever is less.

If such Child is born in an Out-of-Network hospital because the Subscriber's Spouse has other health plan coverage, or if such Child is an adopted child born in an Out-of-Network hospital, nursery charges are covered up to the Allowance or Allowable Charge incurred or $2,000, whichever is less.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Miscellaneous Health Interventions" is hereby amended to add the following new Subsections.

Gastric Pacemaker Coverage. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage including the Deductible, Copayment and and/ or Coinsurance set out in the Schedule of Benefits, coverage is provided for gastric pacemakers that receive Prior Approval from Health Advantage. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the gastric pacemaker meets the Primary Coverage Criteria requirements set out in Subsection 2.2. and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. All services, including any gastric pacemaker receiving Prior Approval, must still meet all other coverage terms, conditions, and limitations, and coverage for any gastric pacemaker receiving Prior Approval may still be limited or denied if, when the claims for the gastric pacemaker are received by us, investigation shows that a benefit exclusion or limitation applies, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage.**

Pilot Project Coverage. Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, from time to time, Health Advantage may provide coverage of medical interventions that are excluded under the terms of the Plan as set out in this Evidence of Coverage, under terms, conditions, exclusions and limitations of a Company authorized Pilot Program. You can learn the medical interventions that are covered by a Company authorized Pilot Program, and the terms, conditions, exclusions and limitations of such coverage by visiting Health Advantage's website at WWW.HEALTHADVANTAGE-HMO.COM. or by calling Customer Service.

SPECIFIC PLAN EXCLUSIONS, Health Care Providers is hereby amended to add the following new Subsection. All remaining Subsections are re-numbered to correlate with the change.

Provider, Excluded. Health Interventions received from any Provider who has been excluded from participation in any federally funded program, are not covered.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Gastric Electrical Stimulators" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Group Therapy" is hereby deleted in its entirety. All remaining Subsections are hereby re-numbered to correlate with the change.

CLAIM PROCESSING AND APPEALS, Claim Processing, "Explanation of Benefit Determination" Subsection a. is hereby amended to read as follows.

The specific reason or reasons for the determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Member may learn the diagnosis and treatment codes and their descriptions);

CLAIM PROCESSING AND APPEALS, Claim Appeals to the Plan (Internal Review), "Documentation" Subsection b. is hereby amended to read as follows.

Appellant's Right to Information. Health Advantage shall provide you free of charge and sufficiently in advance of the date of the final internal adverse benefit determination to give you a reasonable opportunity to respond, reasonable access to, and copies of, all documents, records or other information that:

i. were relied upon in making the benefit determination;

ii. were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;

iii. demonstrate compliance with the terms of the Plan.; or

iv. constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

CLAIM PROCESSING AND APPEALS, Claim Appeals to the Plan (Internal Review), "Notification of Determination of Appeal to Plan" Subsection a. is hereby amended to read as follows.

The specific reason or reasons for the review determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Member may learn the diagnosis and treatment codes and their descriptions);

CLAIM PROCESSING AND APPEALS, Independent Medical Review of Claims (External Review) "Claim Appeals Subject to External Review", is hereby amended to read as follows.

1. **Claim Appeals Subject to External Review.**

   a. **Waiver of Internal Review.** If we have waived internal review, your appeal shall be to external review in accordance with this Section 7.4.

   b. **Application of Primary Coverage.** If your claim has not been the subject of a prior external review and if we have denied your claim in whole or in part

because the intervention did not meet the Primary Coverage Criteria (other than under the conditions outlined in Subsections 2.4.1.a., b., c. or d.) or because of the application of a Coverage Policy, you may request an independent medical review by an Independent Review Organization in accordance with the provisions of this Subsection 7.4 provided:

i. The claim denial was upheld in whole or in part as a result of the Plan's internal review process, or

ii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination involving a pre-service claim appeal within thirty (30) days following receipt of your appeal to the Plan; or

iii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination involving a post-service claim appeal within sixty (60) days following receipt of your appeal to the Plan; or

iv. Your claim meets the requirements for expedited external review, (see Subsection 7.4.14) and you have simultaneously submitted an appeal to the Plan.

2. **Where and When to Submit External Review Appeal. .** You may request external review by sending a request marked "External Review Request" to Member Response Coordinator, Post Office Box 8069, Little Rock, Arkansas 72203. Alternatively, you may e-mail our request to APPEALS@HEALTHADVANTAGE-HMO.COM. Your request must be made within four (4) months after you were notified that the claim denial was upheld in whole or in part as a result of the Plan's internal review process. If Subsection 7.3.1.b.ii. or 7.3.1.b.iii. apply, your request may be made at the end of the thirty (30)day period or sixty (60) day period. If Subsection 7.4.1.b.iv. applies, you must file your request for external review at the same time you file your appeal to the Plan.

3 **Filing Fee.** You are required to pay a twenty-five dollar ($25) fee to submit an appeal for external review. If the external review results in a reversal of the claim denial, in whole or in part, Health Advantage will refund your filing fee. This twenty-five dollar ($25) filing fee will be waived if (1) you have previously paid seventy-five dollars ($75) in filing fees during the plan year or (2) paying of the fee will impose an undue financial hardship.

4. **Independent Review Organization and Independent Medical Reviewer**

a. **The Arkansas Insurance Commissioner** shall determine if the claim is subject to external review, and if he so determines, assign an Independent Review Organization from the list of approved Independent Review Organizations compiled and maintained by the Commissioner.

b. **The Independent Review Organization** is not affiliated with, owned by or controlled by Health Advantage. Health Advantage pays a reasonable fee to the Independent Review Organization to conduct the review, but such fee is not contingent upon the determination of the Independent Review Organization or Independent Medical Reviewer.

c. **An Independent Medical Reviewer** is a physician that is licensed in one or more States to deliver health care services and typically treats the condition or illness that is the subject of the claim under review. The Independent Medical Reviewer is not an Subscriber of Health Advantage and does not provide services exclusively for Health Advantage or for individuals holding insurance coverage with Health Advantage. The Independent Medical Reviewer has no material financial, familial or professional relationship with Health Advantage, with the Plan Administrator, with an officer or director of Health Advantage or the Plan Administrator, with the claimant or the claimant's Authorized Representative, with the health care professional that provided the intervention involved in the denied claim; with the institution at which the intervention involved in the denied claim was provided; with the manufacturer of any drug or other device used in connection with the intervention involved in the denied claim; or with any other party having a substantial interest in the denied claim.

5. **Documentation**

   a. **Written Appeals.** You must submit your appeal in writing in a form and in a manner determined by the Arkansas Insurance Commissioner. You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim.

   b. **Authorization to Release Information.** In filing your request for external review, you must include the following authorization: "I, [Member's name], authorize HMO Partners Inc. d/b/a Health Advantage and my healthcare Provider(s) to release all medical information or records pertinent to this claim to the Independent Review Organization that is designated by Health Advantage. I further authorize such Independent Review Organization to release such medical information to any Independent Medical Reviewer(s) selected by the Independent Review Organization to conduct the review."

6. **Referral of Review Request to an Independent Review Organization.** Upon receipt of the documentation set out in Subsection 7.3.5, the Arkansas Insurance Commissioner shall immediately refer the request for external review, along with Health Advantage's initial determination of the claim and the Appeals Coordinator's internal review determination (if applicable) to an Independent Review Organization.

7. **Independent Review Organization Right to Information.** You and your treating health care professional are required to provide the Independent Review Organization and the Independent Medical Reviewer(s), upon request, access to information necessary to determine the appeal. Access to such information shall be provided not later than seven (7) business days after the date on which the request for information is received.

8. **Rejection of Request for Review by the Independent Review Organization.** The Independent Review Organization shall reject a request for review and notify you, your Authorized Representative and the Appeals Reviewer in writing within five (5) business days (or within 72 hours for an Expedited Appeal) of its determination, if it determines that the appeal does meet the standards for an appeal for external review. See Subsections 7.3.1.

9. **Rejection of the Review for Failure to Submit Requested Information.** The Independent Review Organization may reject a request for review if:

   a. you have not provided the authorization for release of medical records or information pertinent to the claim required by Subsection 7.3.5.b; or

   b. you or your health care professional have not provided information requested by the Independent Review Organization in accordance with Subsection 7.3.7

10. **Independent Medical Review Determination.** If the Independent Review Organization does not reject the request for review in accordance with Subsections 7.3.8 or 7.3.9, it shall assign the request for review to an Independent Medical Reviewer. Such Independent Medical Reviewer shall make a determination after reviewing the documentation submitted by you, your health care professional and Health Advantage. The Independent Medical Reviewer shall consider the terms of the Evidence of Coverage to assure that the reviewer's decision is not contrary to the terms of the Plan. In making the determination the reviewer need not give deference to the determinations made by Health Advantage or the recommendations of the treating health care professional (if any).

11. **Timing of Appeal Determination.**

   a. **Standard Review.** The Independent Medical Reviewer shall complete a review on an appeal within a reasonable period of time, but in no case later than forty five (45) days after the Independent Review Organization received the appeal.

   b. **Expedited Review.** If you request an expedited review, and a health care professional certifies that the time for a standard review would seriously jeopardize your life or health or your ability to regain maximum function, the Independent Medical Reviewer shall make a determination on review in accordance with the medical exigencies of the case and as soon as possible,

but in no case later than 72 hours after the time the Independent Review Organization received the request for review.

12. **Notification of Determination of Independent Medical Review.**

    a. **Recipients of Notice.** Upon receipt of the determination of the Independent Medical Reviewer, the Independent Review Organization shall provide written notification of the determination to you, you health care Provider and Health Advantage.

    b. **The Notification shall include**.

        i. A general description of the reason for the request for external review;

        ii. The date the Independent Review Organization was notified by Health Advantage to conduct the review;

        iii. The date the external review was conducted;

        iv. The date of the Independent Medical Reviewer's determination;

        v. The principal reason(s) for the determination;

        vi. The rationale for the determination; and

        vii. References to the evidence or documentation, including practice guidelines, considered in the determination.

13. **Expedited External Review.**

    a. **Requirement for Expedited Review.** You may submit a pre-service claim denial or a denial of a claim involving concurrent care for an expedited external review provided your health care professional certifies that the time to complete a standard review would seriously jeopardize your life or health or your ability to regain maximum function.

    b. **Expedited External Review without prior Appeal to Plan (internal review).** You may request an expedited review at the same time you submit a request for an appeal to the Plan (internal review) if your health care professional certifies that the time to complete the Plan's expedited appeal process would seriously jeopardize your life or health or your ability to regain maximum function. If you make such a request, the Independent Review Organization may determine and notify you in accordance with Subsections 7.3.11.b and 7.3.12 whether you will be required to complete the internal review process.

    c. **Same procedures as standard external review.** Unless otherwise specified, the provisions of this Section 7.3 applicable to independent medical review of claims apply to expedited external review of claims.

14. **Other Rights under Plan.** Your decision to submit an appeal to external review will have no effect on your other rights and benefits under the Plan.

15. **Arkansas Insurance Commissioner.** You may contact the Arkansas Insurance Commissioner for assistance. The mailing address is Arkansas Insurance Department, Attention External Review Assistance, 1200 West Third Street, Little Rock, Arkansas 72201. The telephone number is 501-371-2640 or toll free 800-282-9134. The e-mail address is insurance.consumers@arkansas.gov.

16. **Binding on the Plan.** The determination of an Independent Review Organization and an Independent Medical Reviewer is binding on both the Plan and you, except to the extent that other remedies are available under applicable federal or state law.

GLOSSARY OF TERMS, Health Interventions is hereby amended to read as follows.

Health Intervention or Intervention means an item, Medication or service delivered or undertaken primarily to diagnose, detect, treat, palliate or alleviate a medical condition or to maintain or restore functional ability of the mind or body.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.

_____

David F. Bridges, President
HMO PARTNERS, INC, d/b/a/ HEALTH ADVANTAGE
P.O. Office Box 8069, Little Rock, Arkansas 72203-8069

SERFF Tracking Number:	*ARBB-127790785*	*State:*	*Arkansas*
Filing Company:	*Arkansas Blue Cross and Blue Shield*	*State Tracking Number:*	*50180*
Company Tracking Number:	*34-63,34-67,34-68,34-107 R1/12, 34-130,34-135,34-137,34-138 1/12*		
TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)*	*Sub-TOI:*	*HOrg02G.002C Any Size Group - HMO*
Product Name:	*General Amendments*		
Project Name/Number:	*Amendments/34-63,34-67,34-68, 34-107 R1/12, 34-130,34-135,34-137, 34-138 1/12*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/03/2011

Comments:
Please see attached.
Attachment:
Flesch Certification Form HA,34-63,34-67,34-68 R1-12,34-130,34-135,34-137,34-138 1-12.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/03/2011
Bypass Reason:	Not required.		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	11/03/2011
Bypass Reason:	Not required.		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	11/03/2011

Comments:
Please see attached.
Attachment:
PPACA Form 34-107 R1-12.pdf

Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

Re: HMO Partners, Inc. d/b/a Health Advantage
Form Nos. 34-63,34-67,34-68, 34-107 R1/12,34-130,34-135,34-137,34-138 1/12

FLESCH READING EASE
CERTIFICATION

This is to certify that the above referenced document has achieved a Flesch Reading Ease Score average of 40.4 and complies with the requirements of A.C.A. §23-80-201 *et. seq.*, cited as the Life and Disability Insurance Policy Language Simplification Act.

/David Bruljes

Name

President

Title

November 2, 2011

Date

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☐ **INDIVIDUAL HEALTH BENEFIT PLANS** *(Complete SECTION A only)*

☑ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** *(Complete SECTION B only)*

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☑ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Health Advantage	95442		All currently approved, group Evidences of Coverage	☐ Yes ☑ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services. Explanation: Page Number:	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. Explanation: Page Number:	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Appeals Process – Requires establishment of an internal claims appeal process and external review process. Explanation: Page Number:	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level. Explanation: Page Number:	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

Reset Form

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: See amendments 34-100, 34-103,34-105			
	Page Number: 3			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: See amendments 34-98 - 34-106			
	Page Number: 1-3			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: See amendments 34-98 - 34-106			
	Page Number: 2			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: See amendments 34-98 - 34-106			
	Page Number: 3			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: See amendment 34-107			
	Page Number: 1			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☑ **Yes**◊ ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: already filed and approved - see amendments 34-88 and 34-89			
	Page Number: 1			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: See amendment number 34-107 R1/12			
	Page Number:			

◊ For plan years beginning before January 1, 2010, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: We currently provide this coverage under all plans			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: See amendments 34-98 - 34-106			
	Page Number: 1			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: See amendments 34-98 - 34-106			
	Page Number: 1			